DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

File

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 7 - 0 0 4

2. STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
1/1/97

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 435.232

7. FEDERAL BUDGET IMPACT:
a. FFY _____ $ _____
b. FFY _____ $ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Page 4 of Attachment 2.6-A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
Post Eligibility Treatment of Institutionalized Individuals

GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not Required under 42 CFR 430.12(b)(2)(i)

11. SIGNATURE OF STATE AGENCY OFFICIAL:

12. TYPED NAME:
Bruce M. Bullen

13. TITLE:
Commissioner, Division of Medical Assistance

14. DATE SUBMITTED:
3/31/97

16. RETURN TO:
Bridget Landers
Coordinator, State Plan
600 Washington St., 3rd Floor
Boston, MA 02111

FOR REGIONAL OFFICE USE ONLY

15. DATE RECEIVED:
3/31/97

18. DATE APPROVED:
6/6/01

PLAN APPROVED - ONE COPY ATTACHED

17. EFFECTIVE DATE OF APPROVED MATERIAL:
1/1/97

20. SIGNATURE OF REGIONAL OFFICIAL:

19. TYPED NAME:
Ronald Preston

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

Citation	Condition or Requirement

435.725
435.733
435.832

B. Post-Eligibility Treatment of Institutionalized Individuals

The following amounts are deducted from gross income when computing the application of an individual's or couple's income to the cost of institutional care:

1. Personal Needs Allowance.

a. Aged, blind, disabled--
Individuals $ 60
Couples $ 120

* The personal needs allowance for SSI recipients in nursing facilities and chronic desease hospitals is $65 per month
* For the following individuals with greater need--
* Amount paid to veteran pursuant to Section 8003, not in excess of $90 per month

b. AFDC related--

Children $ 60
Adults $ 60

c. Individuals under age 21 covered in this plan as specified in Item B.7. of ATTACHMENT 2.2-A.
$60.00

435.725
435.733
435.832

2. For maintenance of the non-institutionalized spouse only. The amount must be based on a reasonable assessment of need but must not exceed the highest of --

SSI level $_____
SSP level $_____
Medically needy level $_____
Other as follows $ 1976 per provisions of Section 1924(d) of the Act